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DISEASES OF THE SPINE AND OF THE NERVES.

16 PAGES.

CLINICS.

CLINICAL LECTURE.

Clinical Lecture on Abscess in different Localities. By FREDERICK C. SKEY, Esq., Consulting Surgeon to St. Bartholomew's Hospital, etc.

There is no disease more universal than abscess, and none that demands from the surgeon clearer pathologic views, and the consideration of which will afford you material for much profitable reflection. It is scarcely necessary to define an abscess. It is a collection of pus contained in a sac or cyst. It may be preceded in its formation by a deposit of solid lymph, greater or less in magnitude; or an abscess may form without previous indication of its existence. Such examples are not infrequently found under the skin, and in various parts of the frame, following diseases which exert an unusually depressing influence on the system—such as fever, dysentery, phthisis,

&c. This latter variety is invariably the product of extreme debility. Now, is this purulent deposit in the tissues of the body the result, as is too often supposed, of real inflammation—that is, of an active hyperæmia—or not? Assuredly it is not. It is associated with, and, more than that, it is the product of, a weak condition of the arterial system, and necessarily of all the vital powers. You will find the pulse, when the disease is extensive, weak; for, even if full and large in calibre, it is readily compressed. I wish you especially to recognize this feature in the formation and progress of simple abscess; the indications of weakness being, of course, greater when the abscess is large. The greater the debility the larger the abscess, and the slower its progress towards maturity and recovery.

You will naturally infer, then, that all abscesses occurring spontaneously, or rather without external and obvious causes, demand treatment by tonics and stimulants,

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and of such I select especially bark and wine. There is no remedy in the Pharmacopœia so potent in producing suppurative action as bark, and of all forms the simple tincture is the most efficient, in full doses of two or three drachms diluted with water. By the term suppurative action, I understand the conversion or breaking down of a mass of lymph, itself quite incapable of removal by the absorbents, into fluid pus—in fact, into abscess.

There is no form of abscess more illustrative of these truths than the disease when situated in the mammary gland, on which I have so often spoken in this theatre. It appears in weakly constitutions following long and severe confinements with loss of blood, or a low and innutritious diet, erroneously supposed to act as a preventive to inflammation, which, in truth, it actually fosters.

I speak of common *mammary abscess*, which appears at varying periods after confinement, in its first stage of deposit of lymph, when occupying a greater or less portion of the entire gland. Now let me assure you that we have no means within the circle of our present knowledge of obtaining the absorption of this solid mass or throwing it back on the constitution. Neither iodine, nor leeches, nor fomentations, nor purgatives, or other supposed remedies confidently proposed by young medical men, who, unfortunately observe little, and think less, are at all available to good. Yet you are aware that they are the agents which two-thirds of you at least would resort to; I am sure of this, for I am told so at every college examination. Pray understand the absolute impossibility of getting rid of this once deposited mass by the means alluded to, and which you are all prepared to adopt. I will not go so far as to say it may not be at least partially dissipated by absorption, but not by your means.

The proportion of the deposit that may be absorbed depends on the stage it has arrived at. If much advanced it will pass on almost entirely into suppuration. It has already entered on that of suppurative action; it will not remain stationary, and it must advance; but whether its progress towards its necessary consummation be slow or rapid, depends on your treatment. I say, in all abscess give bark freely, and generally wine; and the larger quantity of each that your patient can bear, the earlier will this solid mass

break down in the centre and form a large abscess, which, when matured, and not before, should be freely laid open with the knife. If the deposit be recent, and the disease treated early on this sound principle, a portion of the mass will be taken up by the absorbents, indicated by the disproportionate quantity of pus to the large mass that has produced it.

Perineal abscess often presents itself in the form of a small, rounded, hard tumour, by the side of the urethra in the perineum, of about the size of a marble. Whatever you may suppose, or have been told to the contrary, it will answer, in my opinion, no useful purpose to adopt, in this form, any other treatment except that I have recommended to you in the case of mammary abscess. I do not consider it at all necessary to the true pathology of this disease that it should be based on any lesion of the urethra. It is not necessarily, nor by any means invariably, the result of urine infiltrated into the cellular tissue. It results from irritation conveyed to this tissue by the use or abuse of instruments employed in the treatment of stricture, real or supposed. When pus is thoroughly formed—and it is a great object of treatment to attain this end as early as possible—do not open the canal of the urethra, if urine does not pass through the wound. Should it do so there would appear to be even less necessity for this extension or the incision.

It is not always an easy diagnosis to determine whether fluid about the *knee-joint* is within the cavity of the articulation or without it. As a rule the diagnosis is readily attained in these cases. You will tell me that when the fluid extends over the patella, the disease consists of abscess around the joint; and when the patella is raised, and is pushed up by fluid underneath it, the collection is within the articulation. That is all very true. But in many cases the fluid, although confined to the joint, is not sufficient in quantity to raise the patella, and therefore you cannot always depend on that particular evidence; and in the other case, in which, consequent on the greater tenacity and closer adhesion of the integuments to the fibrous tissue upon the patella, I have seen several examples of what I have called the horse-shoe abscess around the knee—viz: when the matter has travelled round three sides of the patella without extending over it. Such cases are very

deceptive. In forming your opinion—and a correct judgment is often indispensable to the recovery of your patient—you would, of course, place your greatest reliance on the local examination by the hand, and, this proving insufficient, weigh deliberately the evidence in favor of one or the other locality. If the fluid be in the joint, it may be a more serious affection, and the constitution takes cognizance of it as such. If external, probably the formation of abscess has been preceded by some local injury of a superficial kind, involving the cellular tissue, and in which the condition of the skin itself may add its testimony.

I now come to abscess on a larger scale. *Abdominal abscess* presents itself in the form of a large tumour, occupying the lower part of the abdominal walls, and commonly extending from the ilium towards the mesial line of the abdomen. The size is sometimes immense. It is firm, solid, and unyielding on pressure, but not very painful. I have known it on several occasions to be mistaken for malignant disease. It will remain stationary for a long period, and when it breaks down into pus, the fluid will extend in various directions, backwards towards the loins, almost invariably along the course of the femoral vessels to the extent of four or six inches; while it occasionally breaks its way through the sacro-ischiatic foramen, and forms an immense tumour on the gluteal region. This disease may be said to place life itself in jeopardy, not merely from its magnitude, but from the depressed condition of the system that produces it. In this feature it resembles carbuncle. I will tell you briefly some few particulars of the first case I ever saw. It occurred to a gentleman of advancing age, who first detected the disease while on a journey in Wales. He consulted a surgeon, who reported to his family that his disease was malignant. He consulted a second authority in the west of England, who echoed the opinion of the former gentleman, and advised his immediate return to London. I saw him in consultation with his friend, the late Dr. Rigby, on the day following. Other medical men were present. My reason for entertaining a doubt as to the malignant nature of the disease was based on the fact of its very recent appearance, which seemed to me fatal to the supposition of malignancy. I considered it a prospective abscess, and I gave him bark and good nourishing diet,

with wine. In the course of ten days the swelling increased largely, and I thought I felt fluctuation. In the presence of several medical men, and in the confidence of my opinion, I punctured the tumour through the abdominal wall; nothing but blood followed the puncture! I then ordered brandy in place of wine, and turtle soup, and a thoroughly animal diet. In four days I again punctured freely, and evacuated about eighteen ounces of healthy pus. He recovered in a month.

In March last I saw a gentleman, aged seventy-five, with a large tumour in the abdomen, occupying the right side, and extending from the iliac fossa. I was told by the family medical attendant that his patient was the subject of malignant disease, that he had been visited by two eminent physicians (and they were both men of deserved eminence), who had pronounced his case hopeless from this cause. With some difficulty, I convinced his medical attendant that the great probability was in favour of abscess; and with his concurrence, I gave him large doses of bark, and about a pint and a half of port wine daily. Within one week, at least one-third of the abdomen was swollen and red, and the hand readily detected large fluctuation of pus, of which fact my colleague was as convinced as I was; but his family objected to an operation, and the poor gentleman carried his abscess to his grave. His attendant nurses were confined to the members of his family, and belonged to the amateur class. Such nursing is not very infrequently fatal to life.

Among the more formidable varieties of abscess, none are more serious than abscess resulting from cellulitis of the tissues within the pelvis, especially when following parturition in weakly women. These are cases which test the courage as well as the knowledge of the surgeon, for matter penned up within the recesses of the body in this complicated region must have exit. *Pelvic abscess* may occur independently of parturition, or during its progress. It is attended by local pain of a severe character, which is aggravated by digital examination. Tenderness on pressure strengthens the suspicion of pent-up matter. An examination per vaginam or per rectum detects either obvious or obscure fluctuation. Unless an early exit to this matter be made, the disease will extend throughout the sub-

peritoneal coat of the uterus, bladder, and rectum. I have known one case in which this cellular inflammation, commencing in the tissue around the rectum, and into which the abscess actually burst, extended upwards around the uterus and bladder, and burst at the umbilicus. I have seen several cases in which the matter made its way through the sacro-ischiatic foramen, and presented along the line of the ischiatic nerve. Whenever the presence of pus is detected, and indeed whenever it is on good evidence even suspected, an exploring needle should be resorted to, followed, if required, by a good-sized chain trocar with its curved canula. In severe cases, nothing short of following up the examination whenever and wherever the presence of matter is indicated by local pain can afford a reasonable prospect of recovery. If, on examination by the rectum, a large collection of pus is detected, and when confirmed on examination per vaginam, a free incision by the side of the rectum through the perineum is more readily executed, and will afford a freer exit to the matter than puncture by means of a trocar through the walls either of the vagina or rectum.—*Lancet*, July 23d and 30th, 1870.

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Case of Chorea, with Clinical Remarks.
By Dr. WILKS.

Charlotte P., æt. 17, was admitted into Guy's Hospital March 16, 1870, with chorea. She had always had good health; never had rheumatism. Four months ago, a brother of the patient's died. She was a good deal alarmed at the sight of the body, and was afraid to sleep in the house until after the funeral; after this she was observed to be silly and knock herself about; she would fall down whilst walking and strike herself against the furniture. During the three weeks before admission, she became rapidly worse, and could only talk with difficulty. She had been in a country infirmary, and was said to have been discharged incurable. She was a well-developed girl; had choreic movements of all parts of the body, the limbs being thrown about. She was scarcely able to articulate, and her answers were foolish and without reference to the question asked. She was quite unable to stand. The heart-sounds were normal. She was ordered two drachms of the *succus conii* four times a day, and to have good living. She continued this treatment

for a fortnight. For a few days she appeared somewhat better; she then became worse, and the pulse reduced to 56. At the end of the fortnight, sulphate of zinc was ordered in grain doses, to be increased every third day; good living, with wine, as before. In about a week she was evidently improving, and then gradually got better, gaining strength and the movements less; and at the present time is able to walk about the ward.

Chorea is a very common disease, and several cases are always in the hospital. Dr. Wilks would therefore give the result of his experience. Having seen a host of remedies given, he was anxious to watch the disease unaffected by any drug; and he had observed that there was always a tendency for the symptoms to abate soon after admission to the hospital. He had placed the fact beyond all doubt by taking cases into the wards and administering no medicine. Some of the most striking results were seen in those who had been out-patients and had taken medicines, but, daily growing worse, were at last admitted within the building. Such children often rapidly recovered; and he attributed the change to their withdrawal from all those surrounding circumstances which were fostering the complaint at home, and to their being placed under moral control, and to the advantages of good living. Such instances might be mentioned without number; but of late there was the case of a girl who was so bad that she was obliged to be protected by sideboards to the bed, but who was well in a month; also the case of another girl who had been under a very intelligent practitioner for a great many months and nothing had been found of service; every medicine which had been proposed for the complaint had been administered, as well as every external remedy, but all of no avail. There was no other medicine left for trial; she was therefore simply placed in bed and ordered good living. She began slowly to recover. Having said so much, Dr. Wilks wished to declare his belief in the great value of tonics, and at the same time in the inutility of all those medicines which have a physiological action on the nervous system. He regarded chorea as a disease of debility, where the cerebro-spinal centres were weakened, and where restoration could be accomplished only by time, good living, and tonics. Thus, although in

many cases recovery took place as rapidly as could be where no medicines were given, yet in many the cure was expedited by the use of tonic remedies. These were the well-known nervine metallic tonics, as zinc, iron, and arsenic. It was well known that the late Dr. Elliotson obtained deserved repute by the success with which he administered the hydrated oxide of iron; this and the sulphate of zinc in increasing doses were the usual remedies at Guy's Hospital. The late Dr. Hughes having an opinion that there was often gastro-intestinal derangement, was in the habit of ordering a draught composed of wine in which rhubarb had been steeped, three times a day. Now, since it would appear from a superficial view of a complaint where there is constant excitement of the nervous system that a sedative would be the appropriate remedy, it is not to be wondered at that there are those in the profession who are always seeking for some drug which will at once cure the complaint. Now from what has been said of the nature of the disease this is most unlikely or even impossible, and thus no surprise need be experienced at the complete failure of such remedies as opium or chloroform. Such medicines will quiet the system for a time, but as soon as their effects are passed off the symptoms return; seeing that the cause, being a chronic one, remains. It is much the same thing as rendering a madman insensible by opium, by which you merely neutralize the effects of the complaint without combating it. With these views and with this experience, Dr. Wilks admitted his incredulity with respect to conium: as, however, it had been so much vaunted, he had used it largely and fairly, but with no very favourable result. In very many cases he had changed it for the older and long approved remedies, when an improvement at once commenced. He warned his class against an error into which many of his pupils fell—that a chorea patient was necessarily better because he was quieter. The child in the first instance had slight irregular movements; subsequently these became more violent, and the patient was unable to stand; then not infrequently the limbs became utterly powerless, whilst the movements became less. He had seen many cases of children who, after violent chorea, lay perfectly quiet in bed, but were almost completely paralyzed in every part of the body. One of the best cases of relief by

conium which had been shown him was the case of a girl who, a few days after taking the drug, became quiet, but although quiet she could not move a limb. Now this condition is often a later stage of the disorder, and does not necessarily show improvement. Even had it been produced by the conium and a condition to be sought for, it was evident that there was need then of the class of medicines which had been advocated; for, probably, no one would recommend conium in choreal paralysis. A patient with chorea cannot be said to be better unless he is stronger at the same time as the movements cease. It may be observed that in most of the published cases of cure by conium, the disease had run a very ordinary course. Dr. Wilks therefore advised his pupils when they had a case of chorea, to remove it if possible from the place where the complaint originated, then to give good living and tonic medicines of the kind indicated. The complaint being a chronic one of debility, they must remove the child from all those conditions which tend to prolong it, and then adopt all the well-known means to restore the tone of the nervous system.—*Brit. Med. Journ.*, July 30, 1870.

Clinical Lecture on Housemaid's Knee; Ranula; and some Forms of Nevus.—By FREDERICK C. SKEY, F. R. S., Consulting Surgeon to St. Bartholomew's Hospital.

There is no feature in the practice of the experienced surgeon more prominent than his appeal to what is termed heroic surgery on compulsion only. Young surgeons, who have not yet become familiar with the responsibility and the danger attached to large operations, are prone to an early resort to the knife before simpler means have been exhausted. It must not be forgotten that the interests of operative surgery invariably suffer from unsuccessful, and still more from fatal, operations; that under the most promising conditions human nature shrinks from its appeal with fear and revulsion; and that failure in one case will probably deter many from submitting to operations which offer results far more encouraging. The real philosophy of medicine and surgery consists in paying due homage to nature, the great restorer of health.

I propose to-day to tell you of the efficacy of a simple thread in the treatment of three not very uncommon diseases, which were

formerly, and indeed at a recent date, subjected to that of a more violent character.

The first of these diseases is that of the enlarged bursa on the patella, known as the *Housemaid's knee*. It is a very common affection, and is productive of great discomfort and inconvenience to its possessor. It is not caused by direct pressure, but, like corns, bunions, and blisters on the hand, &c., it results from oblique traction of the skin in moving from side to side; in fact, from friction. Corns are not limited to people who wear tight boots. These bursæ assume various forms and sizes, from that of a child's ball to that of an orange. They are soft or hard—that is, the bursal cavity may be filled with a serous fluid, or the cavity may be all but obliterated by a thick, fleshy mass of lymph, which forms the body of the tumour. The former are the more common, but both are to be met with, whether in hospital or in private practice. Now what is the treatment you would adopt for the cure? I will tell you. You begin with tincture of iodine—iodine the universal, and, I would add, the worthless. In truth, iodine, as a local remedy in all cases of this description, is almost, if not quite, inoperative to either good or evil. Can any one of you, gentlemen, assure me you have ever seen the smallest advantage derived from it in the treatment of bursæ? If you have, I have not. The next remedy recommended is the repeated application of blisters. I have seen cases in which blisters have been applied to the extent of some eight or ten without benefit, and, indeed, one does not see why they should prove useful in removing either the fluid contents of a bursa or the mass of lymph deposited around it. You will find a stout thread of silk passed through the centre of the tumour far more efficacious than either the iodine or the blisters. To remove these swellings by excision is to return to the barbarous surgery of our forefathers, and you will not do that operation with impunity. It is an operation of expediency, and is not unattended with danger. The effect of the seton thread is to convert the entire mass into an abscess, and this end is generally attained in the course of a week or ten days. Inflammation will follow of a somewhat severe character, if the thread be allowed to remain in the wound after the exudation of pus from the two orifices made by the

needle. The cases therefore require a surgical eye upon them daily after a few days have elapsed. It is now an abscess; it was a bursa; and the abscess, when matured, should be opened freely. I have repeatedly seen the hard mass of the diseased deposit entirely absorbed without suppuration.

Ranula consists in a collection of glairy, albuminous fluid within a cyst formed under the tongue, varying in size from that of a cherry-stone to that of an orange. It is by some authorities considered to be a dilated orifice of a sublingual duct, or of that of the submaxillary gland; by others, that it is a formation independent of these natural orifices. I incline to the former pathology from the fact of my having extracted a small calculus from the orifice of a duct in a case of ranula, on the removal of which the disease underwent a spontaneous cure. When small, and, it may be presumed, in its early stage, the membranous cyst is thin—has the appearance of translucency, and is marked by minute veins coursing over it from below upwards. When at the greatest magnitude I have ever seen it its cyst is thick and fleshy, and it extends from below the floor of the mouth downwards to the level of the cricoid cartilage, forming a large tumour, palpable to sight as well as to touch. Within the mouth it occupies the entire cavity from the floor to the roof, the tongue being pushed backwards, having the apex in contact with the soft palate. Deglutition is greatly impaired, and the attempt to swallow solid food is frustrated by the paralyzed condition of the agents engaged in that act. Thus the constitution suffers from partial inanition, and the disease, trivial enough in its early stages, now makes serious inroads on the physical health.

Now, what are the resources of the surgeon? You will tell me either to snip out a piece of the cyst, or to apply nitrate of silver, or, with heroic daring, to dissect out the entire cyst. But a far simpler and far more efficient remedy than either is a simple thread of silk or flax, passed by means of a much-curved needle through the centre of the tumour. It is desirable that the seton thread be passed through the centre, and not through the side, of the tumour. At the expiration of five or six days, or sometimes earlier, the ranula will be found reduced to less than half its origi-

nal size, leaving the thread at some distance from it, but still clinging to the mucous membrane. Of course you remove this first thread, and apply a second in like manner through the residue of the tumour, which will finally disappear in the course of three or four days. The large cysts I have described, and of which I have treated several, are amenable to the same treatment. The thread must be passed through the long axis of the swelling from the mouth downwards. The needle must be strong and nearly straight, and the thread thick in proportion; and the point of the needle is brought out through the skin at the lowest point at which the swelling is perceptible, and the two ends tied in a knot at the angle of the mouth. The reduction in the size of the swelling may be dated from a short interval of a few days from that of the introduction of the thread. I have never failed to effect a complete cure of ranula by these means, be the disease large or small; and the pain attendant on the entire treatment amounts to almost nothing. There is no danger of hemorrhage from the introduction of the needle in the large cases, because the tumour in the neck is superficial, leaving the carotid artery and its branches in their natural relations to the structures beneath it. The only vessel requiring observation and avoidance is the external jugular vein.

The seton-thread is a very efficient agent of cure in some cases of *Nævus*. It is not superior to treatment by escharotics in all cases. It is slow in its action, requiring the lapse of weeks; but it has the advantage of saving the skin from destruction, and of leaving a less palpable scar than any other remedy with which I am acquainted. If the *nævus* is large, the threads should be passed across the morbid growth in various directions, and not necessarily through the centre, but occupying its substance in all directions. The swelling, if large, may require six, eight, or ten threads. The object to be obtained is suppuration, and when obtained, and detected by the oozing of pus, the thread or threads should be removed; and, if conveniently placed for the purpose, a little pressure should be applied.—*Lancet*, July 30, 1870.

HOSPITAL NOTES AND GLEANINGS.

Cases of Pleuritic Effusion, treated in London Hospital, with Remarks, by Dr.

SUTTON.—The treatment of all diseases that are very common must always be of interest to the profession; and there are few diseases more common than pleurisy. If we compare the treatment of pleurisy as advised in standard works on medicine with what is seen in daily hospital practice, we cannot but be struck with the activity recommended in books, and with the mild, cautious, and, in many cases, expectant system pursued in several of our hospitals. In pleurisy, as with many other diseases, the rule would now appear to be to treat each case on its own merits; and this must necessarily be the case when we consider that the attack must vary with the cause of the disease; for instance, pleurisy excited by pyæmia will run a very different course from pleurisy supervening in the course of rheumatic fever. Pleurisy excited by tubercular abscess near the surface of the lung, tends to run a different course from pleurisy coming on at the end of scarlatina.

Case of free Pleuritic Effusion; Influence of Rest; Recovery.—There have lately been at the London Hospital several cases of pleuritic effusion which appear to us to be very instructive. In illustration of the expectant treatment of pleuritic effusion, we may mention a case that was recently under the care of Dr. Sutton. The patient, a man about forty years of age, was admitted into the London Hospital with large pleuritic effusion on the left side. He was ordered to remain in bed; and, with a view of satisfying him, half a drachm of a solution of acetate of ammonia was administered three times a day. The patient had no other medicine, nor any application to his chest. The treatment was absolute rest, and he recovered remarkably well. This patient had been ill about two weeks before coming into the hospital. He complained of cough and shortness of breath. On examination, he was found to have a very large effusion into the left pleural sac. There was absolute dullness in the lower three-quarters of the left chest. Respiration was inaudible, excepting close to the spine and over the apex of the lung. Tactile vocal fremitus was absent. The heart's apex-beat was felt close to the right nipple; the other organs appeared normal. He remained in bed one month;

and, at the expiration of that time, the effusion had entirely disappeared. Respiration was audible very distinctly all over the left side, accompanied by a friction sound; the dulness had disappeared, and the heart had returned to its normal position. This patient left the hospital about five weeks after admission, convalescent.

Pleuritic Effusion; Treatment by Rest; Recovery.—A second case was a male, aged 16 years, who was in the London Hospital with well-marked evidence of one pleural cavity being almost full of fluid. The heart was very much displaced to the opposite side. With the exception of this effusion, the patient appeared healthy. He was ordered to remain in bed; no medicine was administered; nothing was applied to his chest; and the effusion entirely disappeared. In the course of six weeks he was discharged cured. Dr. Sutton has seen this patient several times since, going about quite well.

Pleuritic Effusion; Treatment by Rest; Recovery.—The third case was that of a middle-aged man in the Hospital, under the care of Dr. Ramskill. There was a large effusion on one side. He was ordered to remain in bed, and a little coloured sugar and water was administered. In a month he was convalescent, the effusion having disappeared.

Remarks.—There have been other cases in the hospital of a similar kind. Dr. Sutton remarked that pleuritic effusion of recent origin which has come on within the last two, three, or four weeks, has thus been observed to disappear when treated by absolute rest, unaided by medicine or any external application; and the same thing has been seen where there was considerable but recent effusion into other serous cavities. Ascites due to cirrhosis of the liver disappeared in a patient who was in the hospital, and treated by rest only; and the patient was convalescent, and left the hospital in the course of a month. The same favourable result has been witnessed with pericardial effusion during the course of rheumatic fever. Dr. Sutton further said that, when we see that patients having recent pleuritic effusion may entirely recover in the course of a few weeks, without the aid of medicine or treatment excepting rest, it is a strong argument against the operation of tapping the chest, and this operation is very rarely required when the effusion is recent and consists of serous fluid. It is,

however, urgently demanded, and must be done to save life when the effusion consists of pus.

The presence of pus is accompanied by difficult and frequent breathing; and experience has shown that the state of respiration is one of the best guides as to whether this operation is required or not. It is considered advisable to tap the chest when there is a large effusion and urgent dyspnoea; and, in Dr. Sutton's experience, it is sometimes requisite, in order to prevent death, to perform this operation when the breathing is very much embarrassed, although the effusion into the pleural cavity may be moderate in quantity. Dr. Sutton remarked that he had more than once been misled in being guided by the quantity of fluid, and not by the state of the breathing.

Moderate Effusion; Sudden Death; Question of Tapping.—Dr. Sutton related the case of a female, aged 43 years, who was admitted into the London Hospital on January 3d, 1868. There was dulness in the lower half of the left side, with absence of respiration and tactile vocal fremitus. The heart was displaced. In the upper part of the lung, the respiration was puerile, and percussion clear. The patient was able to raise herself readily, and sit up in bed, but she seemed anxious to lie down. Breathing was quick and laboured; the face was not livid; the intellect was clear; pulse quick and soft. Seeing that the pleura was only about half full of fluid, it was not considered requisite to tap the chest. A linseed-meal poultice was applied to the side, and a small dose of opium was ordered, to procure sleep. During the night the patient suddenly and unexpectedly died. The autopsy showed about forty ounces of pus in the left pleural cavity, and granular kidneys. The remainder of the body was healthy.

Small amount of Empyema; Great Constitutional Disturbance; Paracentesis; Recovery.—Great constitutional disturbance and difficulty of breathing may be caused by a small effusion of pus into the pleural cavity. This was seen in the case of a sailor under the care of Dr. Ramskill. He was very ill; the breathing was quick and laboured; his pulse was very quick. The patient was seen day by day propped up in bed, in a dreamy semi-delirious state, with sordes about the lips, and a high temperature. Each day he seemed to be growing worse. The physical signs showed

slight effusion over the lower part of the left lung. There was dulness, with diminished tactile vocal fremitus and feeble respiration over the lower third of the left lung. The heart was a little displaced, but it was not to the right of the sternum. As this patient was almost daily becoming worse, it was considered advisable to tap the chest, and about fifteen ounces of pus were withdrawn. The patient improved after the operation; his breathing was very much relieved; and he expressed himself, after a few days, as feeling very much better and stronger. In the case of the female aged 43, as the physical signs did not show any great amount of effusion, it was not considered requisite to tap the chest. The case, however, showed that difficult breathing is a guide much more to be relied upon than the physical signs; therefore, in the second case, seeing that the breathing was very much embarrassed, although the physical signs showed a small amount of effusion, the patient was tapped, with marked and decided benefit. When there is great difficulty in breathing and constitutional disturbance, with a small effusion, and no other disease to account for such dyspnea, we are led to conclude that the fluid in the pleural cavity is pus. In such cases Dr. Sutton has a grooved needle passed into the chest, to ascertain if the effusion consists of pus; and when found to be so it is evacuated.

Remarks.—Empyema and sudden Death; Hydrothorax; Disappearance of Effusion; How long Fluid should be allowed to remain.—It is in cases where the effusion is purulent that death is seen to occur suddenly and unexpectedly. Death caused by acute and recent effusion of serous fluid in the pleura, is very rare excepting as a secondary affection coming on in the course of Bright's disease, or some other organic change. Dr. Gairdner, *Clinical Medicine*, page 374, states that, during eleven years' Hospital practice, he had only seen two persons suffering from acute pleuritic effusion die. Experience, therefore, appears to show that in some cases a large pleuritic effusion will entirely disappear in the course of five or six weeks, and leave the patient, so far as we can estimate, sound. In other cases, the absorption of the fluid is very slow, and at the end of six or eight weeks there is very little change. In such instances, the question arises, Is it safe to allow the fluid to remain longer, for it may

act as an irritant, and excite in the pleura a renewal of the inflammation; the lymph effused may become organized, contract and compress the lung; and in this manner the patient may be permanently damaged. In the treatment of pleuritic effusion, therefore, the most important question is, how long is it safe to allow a large quantity of fluid to remain in the pleural sac without irreparably injuring the lung? The cases referred to as having been under the care of Dr. Sutton, were examples of acute pleurisy with effusion of a few weeks' standing. There was no other appreciable disease of the body. Such are the cases that do well by rest. It will probably be admitted that no one can define what length of time a quantity of fluid may lie in the chest without injuring the lung; for it is remarkable that a large quantity may exist for three or four months, and, after this time, the fluid may gradually disappear, the lung expand, and the patient apparently recover. While recording that such is the fact in a case now and then, it will, perhaps, be allowed that the pleura more frequently becomes greatly thickened when fluid has remained in the chest several months.

Question of Paracentesis.—Considering that the pleura is very liable to become thickened, and the lung bound down in these chronic effusions, some physicians have strongly advocated tapping in an early stage of acute pleurisy. Other physicians, considering that great danger might arise in consequence of air being admitted into the pleural sac, strongly oppose the operation of letting out the fluid. To what extent this danger really exists, has never been clearly defined; and there is strong evidence indicating that the pleura may be tapped and air admitted without any ill effects following. There are the well-known cases of Dr. Hamilton Roe. He operated in twenty-four cases, and a considerable quantity of air entered during the operation in several of them, and in not one case did any evil effects follow. Dr. Bowditch operated in twenty-six cases in which the fluid was serous, and twenty-one made good recoveries.

A Remarkable Case of Pleuritic Effusion; Paracentesis performed eight times; Remarks.—A very instructive case is recorded in the Post Mortem Register of the London Hospital. A patient was on several occasions under the care of Drs. Davies, Ramskill, and Sutton. This patient was a

policemen, and was treated by Mr. Rolfe, who very kindly sent the case to Dr. Sutton, at the Chest Hospital, Victoria Park. The pleura, in this case, was eight times tapped. About one hundred and fifteen ounces were removed on the first occasion; and, on the six subsequent tapplings, from 115 to 130 ounces of fluid were removed; on the eighth occasion, 150 ounces were drawn off. The fluid removed on the first occasion was turbid serum, which, on allowing it to stand, and placing the sediment under the microscope, was found to contain pus-corpuscles; and, on the eighth occasion, a similar fluid was withdrawn. An ordinary trocar was used in the operation, and air entered freely each time; yet, this turbid serum did not become converted into thick pus, nor did the admission of air alter the fluid. It was the same when last withdrawn, as on the first occasion, before any air had entered the pleura. For the sake of brevity, we refrain from giving the details of the case, and confine ourselves to the following observations of Dr. Sutton.

When a large quantity of fluid has been present in the pleural cavity for many months, the parietal and visceral pleura usually become much indurated and thickened. In the case of this patient, who was tapped eight times, both these layers of the serous membrane were converted into a firm, hard, tough, fibroid substance, an inch in thickness. This was the case immediately under the ribs over the lung, and the pleural sac was converted into a large cavity with thick indurated walls. In consequence of this induration and thickening of the pleura, the lung was bound down, and it was impossible for it to expand; therefore, in such cases there is no hope that the lung will ever be able to resume its functions; and it is useless to let out the fluid with the hope that it may do so. The fluid accumulates—and it was so with this patient—in such large quantities that it displaces the heart, encroaches upon the opposite lung, and threatens death by apnoea; therefore, it is necessary to tap the pleural cavity to relieve most urgent distress, and often to ward off immediate death. It is difficult to say how many times a chest may not be tapped. It was, however, observed in this patient, that the fluid increased in quantity, more was removed at each operation, and his power of endurance became each time more feeble; so that the operations distressed him more and more,

and it was evident that to go on in that course would certainly lead soon to his death. It was deemed, therefore, advisable to keep the pleural cavity continually open, and by this means to prevent the fluid from accumulating; and it was hoped that the walls of the sac would gradually contract, and the empyemic cavity be closed. Before this occurred, however, the patient died. It may be instructive briefly to consider what this case appears to show should be our proceedings in any future similar case. It is clear that, in order that the empyemic cavity may be closed, one of two things must occur; either the lung must expand—which in this case was impossible—or the chest-wall must fall in. To bring about the latter, the cavity must be emptied of fluid and air, and then the pressure of the external atmosphere would gradually press in the ribs, and the walls of the cavity would be brought together, adhesions would probably take place, and in this manner the sac would be occluded. It is, therefore, necessary to create a vacuum. If, however, the cavity be filled with air—that is, air allowed to enter in the act of tapping—then the external pressure of the atmosphere is counterbalanced by the internal pressure of the air in the sac. It would then appear that we ought to draw off a portion of the fluid, and not let in any air; then, a week or so afterwards, draw off another portion; and thus by degrees the ribs would be pressed inwards and the cavity be closed. It was hoped that with this patient the indurated pleura would contract, and that this would be promoted by preventing the fluid from accumulating. It is clear, however, that contraction sufficient to obliterate an empyemic cavity having very thick walls must be a very slow process indeed, and may probably take many months, for we know that fibroid tissue contracts very slowly. In the mean time, the presence of air excites chronic suppuration on the internal surface of the sac, and the patient, worn out by a very exhausting discharge, may die of asthenia before the sac is obliterated.—Brit. Med. Journ., July 16, 1870.

Aneurism opening into Left Bronchus avoiding the Recurrent Nerve, wholly without Spasmodic Symptoms.—This case is interesting, because the whole of the left pulmonary plexus of nerves was quite destroyed, while the left recurrent laryngeal escaped, and under these circumstances

there was not any spasmodic affection of larynx. The patient was a man, aged 65, who was in Edgware Workhouse Infirmary, under Mr. Blasjon's care. Mr. Blasjon detected the aneurism, and sent the case to Guy's, under the care of Dr. Moxon. The patient had had an incredible share of serious accidents. The chief of these were that thirty-six years ago he fell and broke his ribs, dislocating his shoulder; afterwards he fell twenty-six feet, and was laid up a long time; then four years ago he was run over across the back of his chest; and since that time he had never been well, but always had pain in his back. For fourteen months he had suffered from cough and occasional hæmoptysis.

On admission he had cough and moderate permanent dyspnœa; sputa in moderate amount of a glairy matter, more or less tinged with bright blood, sometimes of the "currant jelly" character. The left chest was resonant everywhere, but the breathing sound in it was very deficient, almost absent at times, at other times very plain but distant and tubular, no pulsation could be felt. There was no abnormal cardiac murmur, but the second sound was so loud and sharp, that it at once arrested attention. One also *heard a beating* in the left supra-axillary region. There was no enlargement of veins or glands. He did not suffer more than an ordinary case of senile phthisis, and the physical signs alone led to the conviction that the case was one of aneurism. Four days before his death his temperature suddenly rose to 103°, and he felt ill. The sputa became tenacious, and diminished in quantity. He sank with signs of acute pneumonia.

The *post-mortem* gave very neat and convincing, if not conclusive, evidence of the traumatic origin of his aneurism. There was in each chest an old adhesion of the lung, near its root, to the thorax. On each side this was of the size of the palm of one's hand. On the right side the adhesion had certainly nothing to do with the aneurism, which did not affect the right chest, and on the left it extended to a distance beyond the very limited contact of the aneurism with the thoracic wall. These adhesions were just at the spot where in his last accident he had been run over. The aneurism was at a point in the aorta just opposite these adhesions, which it did not cause, nor did they cause it. But a

common cause existed for both, in the passage of a cart-wheel over the spot where these changes were found. The aneurism was fusiform, implicating the whole circumference of the vessel; it was as large as a potato, and from its left side a secondary aneurism had extended into the left lung, whose tissue was compressed before this sac, which had the size of a half orange. The left recurrent laryngeal nerve passed round the aorta just above the aneurism, and was not at all compressed, but perfectly free. But there was no back to the left bronchus for nearly the whole of its course: it was replaced by ragged aneurism clot, which showed a rough surface towards the interior.

This case offers a very exact and conclusive experiment in nervous physiology. Such evidence as it affords is by far more reliable and satisfactory than any results can be which are got by those severe mutilations of animals which are necessary to expose and divide nerves so deeply seated. The effect of it is to support strongly the belief that the irritation of the bronchial plexus does not produce laryngeal spasm. Another very important reflection arises in considering the state of the left lung after the removal of its proper nervous influence. There was no sloughing of the lung, but there was lobular pneumonia producing scattered hepatizations in the centres of the lobules, about the ends of the bronchial tubules. The same condition existed in the right lung to a less extent, although there was no pressure on its pulmonary plexus. Now, very important consequences have been ascribed to destruction of the pulmonary nervous plexuses, especially sloughing of the lung which is not infrequent as a result of aneurismal pressure on its root. Other physicians prefer to think that such sloughing may be due to obstruction of the bronchial artery, which supplies the tissue of the lung. Dr. Moxon held that this case—as well as others that he had seen—opposed these views, and he preferred the following as the true explanation of the broncho-pneumonia of this case, and sloughing in others: namely, that the irritated and compressed bronchus becomes loaded with excess of secretion which it cannot void, and which consequently decomposes more or less, and that these retained secretions set up inflammation that extends to the tissue of the lung, causing more or less

severe inflammation even to the pitch of producing sloughing of its tissue. This occurrence would be equivalent to the inflammation and destruction of the kidney, which occurs in consequence of stricture of the urethra, and retention of urine. Aneurisms pressing the air-tubes usually kill by this pneumonia.—*Med. Times and Gaz.*, July 23, 1870.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Cure for Toothache.—Dr. HENRY T. REYNOLDS, of Baltimore, writes to us that "for eighteen months I have been using acetate of lead as a remedy for what Burns calls 'the hell of all diseases'—toothache. I find it to act better than any of the numerous remedies proposed in the books, and in cases in which it is applicable the relief is instantaneous. Let the patient apply from one to three grains to the cavity for a moment or two, then spit it out. It fails in fewer cases than any remedy that I have tried—not more than eight per cent.

A Simple and Efficient Substitute for the Stomach Pump.—Prof. JOHN T. HODGEN states (*St. Louis Med. and Surg. Journ.*, July, 1870) that about a year ago he had a case of stricture of the œsophagus so narrow that his patient could not swallow even liquids. "To sustain life I resorted to a small stomach tube (a gum catheter, in fact); as a means of injecting liquid nourishment; to this I fixed the elastic tube of one of Davidson's syringes.

On one occasion the vessel containing the liquid happened to be higher than the patient's stomach, and I observed while the syringe was not being used, that the liquid continued to flow into the stomach—the action being that of a siphon. I at once, to test the siphon, substituted a simple elastic tube for the syringe, and found the stomach could be as readily emptied as filled. Thus I conceived the idea of using a siphon instead of a stomach pump, and have used the same in a case of poisoning recently with the most complete success.

I attach four feet of India-rubber tubing to a stomach tube, fill both with water by simply dipping it into the liquid end first, then compressing the elastic tube between the thumb and finger to keep the fluid from

running out, introduce the stomach tube, lower the outer end of the elastic tube, and the contents of the stomach pour out as readily as if from an open vessel. When the fluid ceases to flow, I dip the outer end of the tube beneath the surface of water, elevate the vessel containing it, and the stomach is soon filled; lower again the outer end of the tube and the stomach is emptied. This can, of course, be repeated as often as is necessary.

The advantages claimed for this simple contrivance are, that it may be almost always improvised, is of speedy and easy application, has no valves to become obstructed or deranged, and is less expensive than a stomach pump.

The same principle may be applied in injecting fluid into the bowels, as indeed it has been for injecting into the bladder, uterus, and vagina."

Protracted Gestation.—Dr. L. L. BEDELL reports (*Leavenworth Medical Herald*, August, 1870) having delivered a woman in her sixth pregnancy, June 12, 1870, 10 o'clock A. M., of a healthy female child, weighing nine pounds. After the delivery the mother informed him that her catamenia had ceased July 25, 1869, and that she had expected to be confined about the 1st of May, 1870; that in her previous gestations she had been able to calculate pretty accurately the period of her confinement. If this statement be correct, that her last menstruation ceased July 25, 1869, 10 months and 18 days elapsed before her delivery, or 322 days, and if we deduct 10 days after the disappearance of her menstrual flow, we will still have a period of gestation of 312 days.

Medical Instruction in Philadelphia. *University of Pennsylvania—Medical Department.*—The lectures of the session of 1870-1, in this venerable school, will commence on the second Monday (10th) of October, and close on the last day of February ensuing. The dissecting rooms will be open from the middle of September.

Jefferson Medical College, Philadelphia.—The next annual session will commence on the second Monday in October, 1870. Preliminary lectures will begin on the first Monday in September.

The usual well-known private schools for the instruction of medical students will open on the 1st of September.

These, with the various hospitals, dispensaries, college clinics, and private courses of lectures, will afford every facility for the instruction of students in all departments of professional knowledge.

Tincture of Erigeron in Alveolar Hemorrhage.—Mr. PERKINS states (*Dental Cosmos*, Aug. 1870,) that the tincture of erigeron is more efficacious than Monsel's salt for arresting the troublesome hemorrhage, sometimes following extraction of teeth.

FOREIGN INTELLIGENCE.

Severe Case of Angina Pectoris, relieved by Morphia and Nitrate of Amyl.—E. K., aged 28, laundress, married, was admitted into the Middlesex Hospital, under the care of Dr. Thompson, on June 1, 1870, suffering from the effects of an attack of angina pectoris, which happened two days before. It appears that her father died at the age of 53, with symptoms of angina pectoris. The patient herself has had two attacks of rheumatic fever, both of which occurred in 1861, and since that time has suffered from dyspnoea on exertion, palpitation of the heart, and occasional hæmoptysis. One of her children has been subject from its birth to palpitation, dyspnoea, and blueness of the lips, but is otherwise healthy. During all the time she remained in the hospital (exactly two months) she had frequent attacks of angina pectoris, occurring at first almost every day, but latterly at intervals of nearly a week. While labouring under an attack the typical symptoms of angina pectoris were exceedingly well marked, more especially the dread of death, and the radiating pain, which frequently extended to the head and face, and down both arms and legs. On auscultation a loud purely systolic murmur was heard at the left apex, audible also at the back, and a very faint diastolic murmur at the base.

The treatment adopted during the attacks was as follows: From the day of admission to June 19 all the paroxysms were treated with the subcutaneous injection of morphia, beginning with one-sixth of a grain and gradually increasing the dose till one quarter of a grain was reached. The result of this plan of treatment was uniformly to cut short an attack in about five minutes after the morphia was injected. Owing to the

sickness, vomiting, and headache which often resulted from the morphia, more especially when the dose came to be increased, Dr. Thompson determined to try the effect of the inhalation of nitrate of amyl in controlling the paroxysms. The mode of its administration was simply to allow the patient to inhale the amyl from a bottle, the mouth of which was applied to one nostril. After the inhalation had been cautiously continued for about ten seconds the face became somewhat flushed, the veins slightly prominent, the pulse slower and fuller, and the patient, after drawing a long breath, declared herself quite free of pain. The same train of symptoms happened every time the amyl was inhaled. It never failed to check a paroxysm; it produced no unpleasant after effects; it did not lose its power from repeated use. On the contrary, the occurrence of paroxysms diminished during the time the patient was under this plan of treatment.—*Med. Times and Gaz.*, Aug. 6, 1870.

Effectual Plugging in Epistaxis.—It is generally expected, when the anterior and posterior nares are plugged, that a clot forms on the floor of the nose which compresses the oozing vessels. M. Fano, of Paris, endeavours to compress with more certainty in the following manner: Instead of tying a pledget of cotton or lint to the free end of the thread which has been made to enter at the nose and emerge from the mouth, M. Fano ties a series of little pledgets along that string, in the same fashion as papers are tied to the tail of a kite. The string, being now pulled from the nasal end, is made, by a little management on the velum, to pass behind the latter with its four or five pledgets, until the latter are fairly lodged in the nose, the last pledget of course occluding the aperture of the posterior naris. The front may be plugged as usual. The whole is left four days, and the success, in cases cited by M. Fano, has been remarkable.—*Lancet*, July 2, 1870.

Epidemic Smallpox and Vaccination. There are some important points in the report of M. BESNIER on the epidemic smallpox at Paris which are worthy of notice. Thus in relation to vaccination, the observation has only to be repeated in this as in all epidemics, that the mortality in non-vaccinated cases is very great, and that in-

dividuals who have been vaccinated may, while yet only young, sometimes have lost the benefit derived from vaccination. But a fact revealed by the present epidemic is that vaccinated subjects may furnish also a very considerable mortality. Thus among the smallpox patients at the Maison Municipale de Sante under M. Besnier's care, it was quite exceptional that they had not been vaccinated in childhood, and yet the mortality was at the beginning of the epidemic not less than 18 to 20 per cent. Of 23 patients dying only one had not been vaccinated: 4 exhibited no vaccine scars; but in 18 there were well marked vaccinal cicatrices. In fact, the duration of vaccinal influence may be much more ephemeral than is generally supposed, and during a severe epidemic like the present, all cases without exception should be revaccinated. M. Besnier has just obtained a perfect vaccine pustule in a child 4 years and some months old, who four months before he had vaccinated with complete success, as testified the magnificent cicatrices. The question then arises whether a single inoculation should be considered sufficient, and whether it should not be repeated until no result whatever is produced. So with revaccination, for it is a complete error to suppose that absence of success of revaccination is a proof that the immunity conferred by vaccination persists. It is usually supposed that patients who prove refractory to all attempts at vaccination possess also an immunity from smallpox. During the present epidemic several such have died.

In reference to the treatment of the disease, M. Besnier observes that the hopes entertained by M. Chauffard and others concerning the value of phenic acid have not been realized. As an internal remedy it seems of no avail, but it is a very useful external agent for cleansing the pustules and crusts.

Effects of the Admixture of Races.—Prof. AGASSIZ states: "The physical and moral deterioration resulting from the admixture of pure races is, perhaps, nowhere so clearly shown as in Brazil. The hybrid between the white and the negro, called the mulatto, is too well known to require description. The hybrid between the Indian and the negro, called cafuzo, has none of the delicacy of the mulatto; his complexion is dark, his hair long, wavy, and curling, and his

character, instead of being 'confiding, but indolent,' is described by Agassiz as exhibiting 'a happy combination between the jolly disposition of the negro and the energetic, enduring powers of the Indian.' The hybrid between the white and Indian is called *mameluco*, and is described as being pallid, effeminate, feeble, lazy, and rather obstinate, the Indian influence having apparently obliterated the higher characteristics of the white, without imparting its own energies to the offspring. It is very remarkable that the Indian, whether in crossing with a negro or a white, makes a deeper impress on his progeny than the other races; and, in accordance with this fact, it is observed that, in further crossings, the pure Indian characteristics are resumed, and those of the other races thrown off. 'Let anyone,' says Professor Agassiz, 'who doubts the evil of this mixture of races, and is inclined, from a mistaken philanthropy, to break down all barriers between them, visit Brazil. He cannot deny the deterioration consequent upon an amalgamation of races more widespread here than in any other country in the world, and which is rapidly effacing the best qualities of the white race, the negro, and the Indian, leaving a mongrel nondescript type, deficient in physical and mental energy. Let us profit by the experience of Brazil, and learn the double lesson: open all the advantages of education to the negro, and give him every chance of success, but respect the laws of nature, and preserve, as far as possible, the distinctness of his natural characteristics and the integrity of our own.'—Journey to Brazil, by Prof. and Mrs. Agassiz.

Means of distinguishing Real from Apparent Death.—Dr. LABORDE communicated to the French Academy of Medicine (July 26, 1870) an interesting memoir on some of the physical phenomena of life, and on their application to the distinguishing real from apparent death. He states that if a polished steel needle be inserted to a sufficient depth into the muscles of an apparently dead subject, and allowed to remain, in generally a short time it loses its polish and becomes oxidized; whilst this oxidation does not occur when the needle is introduced into a dead subject, if the needle be allowed to remain even as long as an hour. This absence of oxidation, with concomitant phenomena is, according to Dr. L., a con-

want sign of real death.—*L'Union Médicale*, 28th July, 1870.

OBITUARY RECORD—The great leader of Ophthalmic Surgery, ALBRECHT VON GRAEFE, of Berlin, died on July 20, 1870, in the 45th year of his age. He has gone to his rest in the zenith of his glory, but he has left as a legacy to posterity a record of the facts in the treatment of eye-disease which his master mind had accumulated—foundation-stones, upon which others yet may build. The great work of von Graefe's life was his discovery of the cure of acute glaucoma—a disease which terminates in permanent blindness, and which had hitherto baffled all treatment. It was no mere guess or hazardous trial which led Von Graefe to perform iridectomy for the relief of this terrible affection. Having thoroughly investigated the nature of the glaucomatous process, and having satisfied himself that all the symptoms were due to an increase of the intra-ocular pressure, and that no relief was to be obtained by medicinal means, he sought, by local treatment, to reduce this undue tension to its normal standard. First he tried paracentesis of the cornea, but the result was unsatisfactory: the relief it afforded was generally slight, and, with but few exceptions, it was only temporary. He next turned his attention to the merits of iridectomy—an operation which he had frequently performed in recurrent iritis, irido-choroiditis, and in various extensive corneal affections. The effect of iridectomy in causing a recession of the protrusion in many cases of partial staphyloma of the cornea satisfied him that this removal of a portion of the iris exercised a wonderful influence in reducing the tension of the eye. He resolved, therefore, to apply iridectomy to glaucoma, and in June, 1856, he performed the first operation for the relief of a disease which, up to that date, had been irremediable. In a paper published by Von Graefe in his *Archiv für Ophthalmologie*, and afterwards translated by Mr. Windsor for the Sydenham Society, he concludes by stating that, having followed some of his cases of glaucoma on which he had operated for more than a year, "I think I cannot be mistaken in regarding iridectomy as a true curative treatment of the glaucomatous process"—an opinion which has since been indorsed by all the best ophthalmic surgeons in Europe and America.

Although the cure of glaucoma was the crowning act of Von Graefe's life, yet in all the departments of Ophthalmic Medicine and Surgery he was a great master. In the volumes of the *Archiv für Ophthalmologie* he has written upon almost all the subjects connected with the surgery and pathology of the eye, amongst which the articles on strabismus, detachment of the retina, sympathetic ophthalmia, and cataract, are specially noticeable. His last work was the perfection of his "modified linear extraction" of cataract, an operation which has been attended with very brilliant results.

The world-wide renown which Von Graefe obtained must be attributed rather to the combination in one man of many gifts, than to the extraordinary development of any single quality. His appearance was commanding, fascinating, and imparted confidence; he had great self-reliance, and a certain amount of egotism, a wonderful capacity for work, and a sense of order which prevented a wasteful expenditure of his forces. Thus gifted, he acquired at an early age a reputation which has been almost unprecedented—patients of all classes, from the prince to the pauper, flocked to his hospital for the benefit of his skill; whilst students from all parts of the world crowded to his clinique to witness his manual dexterity, and learn his teachings.

Died, in London, July 18th, JOHN ZACHARIAH LAURENCE, F. R. C. S., M. D., in the 42d year of his age. He was known in this country as an author as well as a surgeon of promise. He was for a time editor of the *Ophthalmic Review*, and, with Mr. Moon wrote a "Handy-book of Ophthalmic Surgery." He also wrote a treatise on cancer, to which the Liston gold medal was awarded by the University College.

— in London, July 12th, JAMES COPLAND, M. D., F. R. S., in the 79th year of his age. Another great name to be added to the list of illustrious dead. Dr. Copland's claim to fame rests mainly on his "Dictionary of Practical Medicine," a great work, which required thirty years to finish. It is a complete *résumé* of all that has been written on the various subjects treated in it, from the earliest days of medicine to modern times, with copious references to all the sources of information. Articles from his pen have appeared in many of the English journals, and at one time he edited the *Medical Repository*.

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